

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155271		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/26/2013	
NAME OF PROVIDER OR SUPPLIER  MILLER'S SENIOR LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 8400 CLEARVISTA PL INDIANAPOLIS, IN 46256			
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 19, 20, 21, 24, 25, and 26, 2013</p> <p>Facility number: 000171 Provider number: 155271 AIM number: 100267050</p> <p>Survey team: Karina Gates, Generalist TC Courtney Mujic, RN (June 19, 20, 21, 24, and 26, 2013) Beth Walsh, RN (June 19, 20, 24, 25, and 26, 2013)</p> <p>Census bed type: SNF: 18 SNF/NF: 51 Total: 69</p> <p>Census payor type: Medicare: 18 Medicaid: 44 Other: 7 Total: 69</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review 7/01/13 by Suzanne</p>			F000000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2013

FORM APPROVED

OMB NO. 0938-0391

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	Williams, RN						

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a community discharge care plan was created for 1 of 24 residents reviewed for care plans. (Resident #139)</p> <p>Findings include:</p> <p>The clinical record for Resident #139 was reviewed on 6/24/13 at 12:45 p.m. He was admitted to the facility on 2/11/13.</p> <p>The 2/19/13 admission MDS (minimum data set) assessment</p>		F000279	<p>F 279 Develop Comprehensive Care Plans</p> <p>Miller's Senior Living respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation with prefix F 279.</p> <p>I. Corrective actions were put in place for resident # 139. This was the only resident found to be affected by the deficient practice. Resident # 139 had a careplan put in place to address his plan for discharge and return to the</p>		07/16/2013	

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	<p>indicated a care plan addressed his return to the community and that he planned to return home after finishing rehabilitation.</p> <p>No care plan was found in Resident #139's clinical record addressing his plan for community discharge.</p> <p>An interview was conducted with the MDS Coordinator on 6/24/13 at 1:24 p.m. She indicated Resident #139's community discharge care plan "did not get done," and (Social Services Director) was responsible for the information contained in the MDS regarding his community discharge.</p> <p>An interview was conducted with the Social Services Director (SSD) on 6/24/13 at 2:32 p.m. regarding a community discharge care plan for Resident #139. She stated, "To be honest, I think I just missed it. I would have addressed his plans to discharge home, and now that he's long term, it would address his future plans, which are uncertain. He should have one in there."</p> <p>3.1-35(a)</p>				<p>community.</p> <p>II. All residents had an audit completed to ensure they were not affected by the deficient practice. No other residents were noted to have this plan of care missing.</p> <p>III. The IDT team that assists in creation of this particular area of care planning was inserviced on the need to have this plan of care in place. Each new admission will be audited and reviewed to ensure they have a care plan that includes discharge plans. Care plans will be reviewed weekly to ensure that each selected resident has a care plan in place that remains appropriate per the resident and the family.</p> <p>IV. The corrective actions will be monitored by the use of the "Discharge Care Plan" QA tool. This will be completed by the DON or designee weekly for 6 months and monthly thereafter.</p> <p>V. All systemic changes will be in place by July 16, 2013.</p>		

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F000282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents' pain was assessed prior to and after PRN (as needed) pain medications were administered and failed to administer blood pressure medication and house supplements/shakes as ordered for 5 of 24 residents reviewed for care plans and physician orders (#155, #142, #42, #3, and #78).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #155 was reviewed on 6/26/13 at 10:30 a.m.</p> <p>Resident #155's diagnoses included, but were not limited to: osteoporosis, cellulitis, and partial left foot amputation.</p> <p>The June 2013 physician's orders indicated hydrocodone 5-325 mg to be given every 4 hours PRN for pain, effective 6/13/13.</p> <p>The June 2013 MAR (Medication</p>			F000282	<p>F 282 Services by a Qualified Person/Per the care plan</p> <p>Miller's Senior Living respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation with prefix F 282.</p> <p>I. Those resident's who were affected by the deficient practice the following corrective actions were put in place.</p> <p>a. Resident 155- The physician saw this patient and noted that the patient has not had any adverse effects as a result of this missing documentation. This order continued and staff were educated to document per policy.</p> <p>b. Resident 142- This resident no longer resides in the facility</p> <p>c. Resident 42- The physician was notified of the deficient practice. The physician noted no adverse effects related to this medication omission. After reviewing this order the physician chose to discontinue the use of this</p>		07/16/2013

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	<p>Administration Record) indicated Resident #155 was given prn hydrocodone on the following dates with the following number of times administered, with no documentation in the clinical record to indicate the resident was assessed for the location or intensity/nature of the pain prior to administering the pain medication or for the effectiveness of the medication after the medication was given:</p> <p>6/17/13 - 2 times 6/18/13 - 3 times 6/19/13 - 1 time 6/22/13 - 1 time 6/23/13 - 1 time 6/24/13 - 3 times</p> <p>Resident #155's 6/14/13 pain care plan indicated the goal was for Resident #155's pain to be resolved within 1 hour of intervention with an intervention to monitor the effectiveness of pain medications.</p> <p>During an interview with the DON (Director of Nursing) on 6/26/13 at 2:27 p.m., she indicated, "I didn't find any assessments for her prn hydrocodone use that were missing."</p> <p>2. The clinical record for Resident #142 was reviewed on 6/26/13 at</p>		<p>medication and subsequent monitoring.</p> <p>d. Resident 3- This order continued and staff were educated to document per policy.</p> <p>e. Resident 78- This order continued and staff were educated to document per policy.</p> <p>II. All residents that have careplans or physician orders for house shakes, PRN pain medication, or as needed blood pressure medication, had their records reviewed and interventions put in place.</p> <p>III. To ensure the deficient practice does not recur all staff were inserviced on the following:</p> <p>a. The policy Titled "Pain Management Program" (Attachment B) as it relates to administration of PRN pain medication and pre and post assessment.</p> <p>b. The importance of following Physician Orders as it relates to administration of Blood Pressure medication</p> <p>c. The importance of following the Plan of Care as it relates to administration of House Supplements.</p> <p>Also, the following systemic changes</p>				

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	<p>11:30 a.m.</p> <p>Resident #142's diagnoses included, but were not limited to: lower leg amputation and osteomyelitis/gangrene.</p> <p>The June 2013 physician's orders indicated hydrocodone 10/325 mg to be given every 4 hours PRN for pain, effective 5/23/13.</p> <p>The June 2013 MAR (Medication Administration Record) indicated Resident #142 was given prn hydrocodone on the following dates the following number of times with no documentation in the clinical record to indicate the resident was assessed for the location or intensity/nature of the pain prior to administering the pain medication or for the effectiveness of the medication after the medication was given:</p> <p>6/13/13 - 1 time 6/14/13 - 3 times 6/15/13 - 1 time 6/21/13 - 2 times</p> <p>Resident #142's 4/4/13 pain care plan, revised 6/10/13, indicated the goal was for Resident #142's breakthrough pain to be resolved within 1 hour of intervention with an</p>			<p>were put in place to ensure the deficient practice does not recur:</p> <p>House shakes are now documented on our Point of Care documentation which is completed by CNAs. The Dietary department is also now preparing house shakes prior to each meal and the house shake is labeled for the appropriate resident with the appropriate size shake.</p> <p>IV. The corrective actions will be monitored by use of the following QA tools:</p> <p>a. MAR (medication administration review) Review for the monitoring of Pain Management (Attachment C)</p> <p>b. MAR (medication administration review) Review for the monitoring of Blood Pressure Medication (Attachment C)</p> <p>c. POC (Point of Care) Review (Attachment D)</p> <p>These tools will be completed by the DON or Designee 5 x per week for 6 weeks. 2 x per week for 6 weeks, weekly for 12 weeks, and monthly thereafter.</p> <p>V. The systemic changes will be completed by July 16, 2013.</p>			

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	<p>intervention to monitor the effectiveness of pain medications.</p> <p>During an interview with the DON (Director of Nursing) on 6/26/13 at 2:34 p.m. she indicated, "I did not find any pre or post assessments for those dates (6/13, 14, 15, and 22/13)."</p> <p>The Pain Management Program policy was provided by the DON on 6/26/13 at 2:25 p.m. It indicated, "Evaluation of effectiveness will be determined by reassessing level of pain 30-60 minutes post medication administration."</p> <p>3. The clinical record for Resident #42 was reviewed, on 6/24/13 at 10:30 a.m. The diagnoses for Resident #42 included, but were not limited to: hypertension, dementia, and diabetes mellitus.</p> <p>A review of the June Physician's Orders indicated an order for blood pressure checks four times a day at 6:00 a.m., 12:00 p.m., 6:00 p.m., and 12:00 a.m., to determine if hydralazine (blood pressure medication) 50 mg (milligrams) was needed. Hydralazine was to be given, if SBP (systolic blood pressure) was greater than 150.</p>						

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	<p>The following blood pressures were recorded on the June MAR (medication administration record): 6/11/13 at 6:00 p.m.-160/93, 6/13/13 at 12:00 p.m.-171/92, 6/14/13 at 6:00 p.m.-153/88, 6/15/13 at 6:00 p.m.- 178/81, 6/17/13 at 12:00 p.m.-165/90, 6/21/13 at 6:00 p.m.-209/97.</p> <p>A review, of the section, on the June MAR which indicated hydralazine 50 mg was administered, was blank, on the following days: 6/11/13, 6/13/13, 6/14/13, 6/15/13, 6/17/13, and 6/21/13.</p> <p>During an interview, on 6/24/13 at 2:15 p.m., with RN #2 and QMA #3, they indicated when a medication was administered, specifically the hydralazine for Resident #42, the MAR on the above dates would have a mark or initials, in the section for that specific date, indicating the medication was administered.</p> <p>On 6/24/13 at 2:20 p.m., the DoN (Director of Nursing) indicated all staff were to follow Physician's Orders, as written.</p> <p>At 2:45 p.m., on 6/24/13, the DoN indicated she noted the June MAR had missing documentation and she</p>						

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	<p>was unsure if the medication was given as ordered, since there was no documentation that the hydralazine was administered. She also indicated, at that time, she would further look into the administration of the hydralazine, on the above dates.</p> <p>During an interview with the DoN, on 6/25/13 at 10:50 a.m., she indicated she was unable to find any proof or documentation that the hydralazine was given, as ordered, on the above dates.</p> <p>4. The clinical record for Resident #3 was reviewed, on 6/24/13 at 11:00 a.m. The diagnoses for Resident #3 included, but were not limited to: end stage renal disease, anemia, and hypertension.</p> <p>A review of a Physician's Order written on 6/21/13, indicated an order for a 4 oz. house shake with breakfast, lunch, and dinner. Document amount accepted in plan of care.</p> <p>A nutritional care plan, dated 5/1/13, indicated an intervention was to receive a 4 oz. house supplement at lunch.</p> <p>During a random observation, on</p>						

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	<p>6/24/13, from 12:05 p.m. when Resident #3 was served his lunch, to 12:37 p.m. when Resident #3 left the upstairs dining room, he did not receive a 4 oz. house shake.</p> <p>A review of the June MAR, on 6/25/13 at 2:30 p.m., indicated he did not receive his house shake, on 6/24/13, by the blank space on the MAR for the date of 6/24/13 at lunch. The 6/24/13 dinner space and the 6/25/13 breakfast space were filled on the June MAR.</p> <p>A review of the June MAR, on 6/26/13 at 1:00 p.m., indicated an error was made, in the dated space for 6/24/13 at lunch, with a handwritten note of "err" in the space and a circle with initials in the space.</p> <p>During an interview with the DoN, on 6/26/13 at 1:20 p.m., she indicated if the June MAR was blank, in the 6/24/13 lunch space for a house supplement, the previous day, on 6/25/13 and there was an "err" with initials and a circle, in the dated space for 6/24/13 lunch, on 6/26/13; then resident did not get his house shake, on 6/24/13 at lunch and the MAR was incorrectly documented and was put on the wrong date.</p>						

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	<p>5. The clinical record for Resident #78 was reviewed, on 6/25/13 at 10:30 a.m. The diagnoses for Resident #78 included, but were not limited to: diabetes mellitus, hypertension, and dementia with Lewy Bodies.</p> <p>A review of the June Physician's Orders, indicated an order for 8 oz. house shakes with meals.</p> <p>A nutritional care plan, last dated 6/24/13, indicated an intervention of being served 8 oz. house supplements at all meals.</p> <p>During a random observation, on 6/26/13, from 12:25 p.m., when Resident #78 received his meal till 12:43 p.m., when Resident #78 left the upstairs dining room, Resident #78 only received 4 oz. of a house supplement.</p> <p>During an interview with LPN #1, on 6/26/13 at 12:45 p.m., she indicated Resident #78 only received 4 oz. of a house supplement and she was unsure if Resident #78's physician orders changed.</p> <p>Another review of the clinical record for Resident #78, on 6/26/13 at 12:47 p.m., did not indicate any new Physician's Order for a change to the</p>						

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	<p>house supplement.</p> <p>On 6/26/13, at 1:20 p.m., the DoN indicated she would look into Resident #78's orders to ensure no new orders were received for a change in house supplement/shake size.</p> <p>No further information was provided on any new orders for Resident #78 prior to final exit from the facility, on 6/26/13.</p> <p>3.1-35(g)(2)</p>						

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure resident safety, in that chemicals were not properly locked up in a housekeeping closet during a random observation. This had the potential to affect 5 of 31 residents who were cognitively impaired and independent in locomotion, out of a total of 49 residents who reside on the second floor. Resident #'s 49, 71, 56, 63, 112.</p> <p>Findings include:</p> <p>During a random observation on 6/19/2013 at 12:10 pm, the housekeeping room next to resident room 230 was open. The handle on the door was locked, but the door was not closed tightly, so it easily opened. Inside, on a shelf, were the following chemicals: One full spray bottle of blue liquid labeled 'Armor Technology for Your Floors'. Four full bottles, with plastic snap lids, labeled, 'lime off descaler'.</p>		F000323	<p>F 323 Free of Accident Hazards/Supervision/Devices</p> <p>Miller's Senior Living respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation with prefix F 323.</p> <p>I. To immediately correct this deficient practice the door that was found to be ajar, was adjusted so that the automatic closure was sped up to assist in making sure the door closes after staff access the chemicals.</p> <p>II. All doors that have automatic closures were checked to ensure they were not risking being left ajar.</p> <p>III. All staff will be inserviced that Toxic and Dangerous supplies will be kept in a secured storage area so they are not accessible to residents without adequate supervision and that all potentially hazardous material will be kept in secured areas that are not easily accessible to residents.</p>		07/16/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155271		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 06/26/2013	
NAME OF PROVIDER OR SUPPLIER  MILLER'S SENIOR LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 8400 CLEARVISTA PL INDIANAPOLIS, IN 46256			
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	<p>A 'Material Safety Data Sheet' (MSDS), provided by the Executive Director on 6/20/2013 at 1:20 pm, indicated, "Product name: Lime off. Generic name: non-foaming descaler. Section 6- Storage and Handling Information: Corrosive... Avoid contact with eyes, skin, and clothing...."</p> <p>A 'Material Safety Data Sheet' (MSDS), provided by the Executive Director, on 6/20/2013 at 1:20 pm, indicated, "Armor Technology for Your Floors...Health Hazard Data: Primary routes of entry: skin contact, eye contact, inhalation. Signs and symptoms: Irritation of: skin, eyes and respiratory tract...."</p> <p>An interview with the Housekeeping Manager, on 6/19/2013 at 12:12 pm, in reference to the the housekeeping closet door, indicated, "It (the door) should be locked; they probably didn't close it tight."</p> <p>A list of BIMS (brief interview for mental status) scores for residents who resided on the second floor, was provided by the Executive Director, on 6/20/2013 at 9:30 am. The following residents had a BIMS score of less than 9 (cognitively impaired);</p>				<p>IV. The corrective actions will be monitored by use of the Hazard Chemical Review QA Tool. This will be completed by the Administrator or Designee 5 x per week for 6 weeks, weekly for 3 months and monthly thereafter.</p> <p>V. All systemic changes will be in place by July 16, 2013</p>		

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	<p>Resident #49: BIMS score: 3 Resident #71: BIMS score: 8 Resident #56: BIMS score: 4 Resident #63: BIMS score: 5 Resident #112: BIMS score: 3.</p> <p>A document, "Residents who are independent in locomotion on the unit," provided by the Executive Director, on 6/20/2013 at 9:30 am, indicated the following; Resident #49: Locomotion: propels self. Resident #71: Locomotion: ambulates. Resident #56: Locomotion: ambulates. Resident #63: Locomotion: propels self. Resident #112: Locomotion: ambulates.</p> <p>An interview with the Executive Director, on 6/26/2013 at 3:21 pm, indicated there is no policy pertaining to keeping chemicals behind locked doors; however, MSDS precautions should be followed.</p> <p>3.1-45(a)(2)</p>						